**TAB 2 –ENROLLMENT**

**Program: ETH Empower DB#:**

|  |  |  |
| --- | --- | --- |
| **Client Name:** | **Date Completed** | **Initials of Staff Person Completing** |
| CSBG - PH |  |  |
| Service & Participant Agreement  *-Provide copy to participant* |  |  |
| Housing History Assessment |  |  |
| Self Sufficiency Action Plan |  |  |
| Budget Worksheet  *-Provide copy to participant* |  |  |
| Housing Search Case Plan  *-Provide copy to participant* |  |  |
| Services Tracking Form |  |  |
| Confidentiality Agreement |  |  |
| EMPOWER Intake form or printout |  |  |
| Staff Certification of Eligibility  -Must have Supervisor signature before any financial assistance is requested |  |  |
|  |  |  |

**Customer Intake Application**

|  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Client Number:** | **Agency:** | | | | | | | | | | **Application Date:** |
|  | Community Action Commission of Fayette County- Peace House | | | | | | | | | |  |
| **Primary Applicant First Name** | | | | | **M.I.** | | | **Last Name** | | | |
|  | | | | |  | | |  | | | |
| **Social Security Number** | | | | | **Date of Birth** | | | **Gender** | | | |
|  | | | | |  | | | 🞎 Female 🞎 Other  🞎 Male | | | |
| **Household Information:** | | | | | | | | | | | |
| **Household Size:** | | | **Family Type** | | | | **Building Type** | | | | |
|  | | | Single Parent/Female  Single Parent/Male  Two-Parent Household  Single Person  Two Adults/No Children  Non-related Adults with children  Multigenerational Household  Other | | | | Mobile Home  Single Family  Multi-family low rise (3 stories or less)  Multi-family high rise (3 stories or more) | | | | |
| **Housing Status** | | |
| Own  Rent  Other Permanent Housing  Homeless  Other | | |
| **Customer Address:** | | | | | | | | | | | |
| Current Service Address: | | | | | | Apartment/Lot/Unit Floor: | | | | | |
|  | | | | | |  | | | | | |
| Current Mailing Address (if different from above): | | | | | | Apartment/Lot/Unit Floor: | | | | | |
|  | | | | | |  | | | | | |
| City: | | State: | | | | Zip Code: | | | | County: | |
|  | |  | | | |  | | | |  | |
| Phone Number: | | | | | | Email Address: | | | | | |
|  | | | | | |  | | | | | |
| Preferred method of contact? | | | | | | | | | | | |
| **Primary Applicant Demographic Information:** | | | | | | | | | | | |
| **Ethnicity** | | | | | **Race** | | | | **Education** | | |
| Hispanic, Latino or Spanish Origins  Not Hispanic, Latino or Spanish Origins | | | | | American Indian/Alaskan Native  Asian  Black/African American  Native Hawaiian/Other Pacific Islander  Other  Unknown/Not-reported  White | | | | Grade 0-8  Grades 9-12/Non-Graduate  High School Grad/GED  12+ Some Post-Secondary  Education  2 or 4 Year College Graduate  Graduate or other post-secondary school | | |
| **Client Disabled?** | | | | | **Military Status** | | | | **Is Client a US Citizen?** | | |
| Yes NO | | | | | Veteran  Active Military  Non Veteran | | | | Yes No | | |
| **Work Status** | | | | | **Health Insurance Type** | | | | **Non-Cash Benefits** | | |
| Employed full-time  Employed part-time  Migrant Seasonal Farm Worker  Unemployed (6 months or less)  Unemployed (more than 6 months)  Unemployed (not in labor force)  Retired  Unknown/not reported  Youth ages 14-24 who are neither working nor in school  N/A | | | | | Medicaid  Medicare  Private/Employment Based  Self-Insured/Direct Pay  None  State Children’s Health Insurance Program  State Health Insurance for Adults | | | | Affordable Care Act Subsidy  Childcare Voucher  Housing Choice Voucher  HUD-VASH  Other  Permanent Supportive Housing  Public Housing  SNAP  WIC  None | | |
| **Additional Household Members:** | | | | | | | | | | | |
| **First Name** | | | | **M.I.** | | | | **Last Name** | | | |
|  | | | |  | | | |  | | | |
| **Social Security Number** | | | | **Date of Birth** | | | | **Gender** | | | |
|  | | | |  | | | | 🞎 Female 🞎 Other  🞎 Male | | | |
| **Ethnicity** | | | | **Race** | | | | **Education** | | | |
| Hispanic, Latino or Spanish Origins  Not Hispanic, Latino or Spanish Origins | | | | American Indian/Alaskan Native  Asian  Black/African American  Native Hawaiian/Other Pacific Islander  Other  Unknown/Not-reported  White | | | | Grade 0-8  Grades 9-12/Non-Graduate  High School Grad/GED  12+ Some Post-Secondary  Education  2 or 4 Year College Graduate  Graduate or other post-secondary school | | | |
| **Client Disabled?** | | | | **Military Status** | | | | **Is Client a US Citizen?** | | | |
| Yes No | | | | Veteran  Active Military  Non Veteran | | | | Yes  No | | | |
| **Work Status** | | | | **Health Insurance Type** | | | | **Non-Cash Benefits** | | | |
| Employed full-time  Employed part-time  Migrant Seasonal Farm Worker  Unemployed (6 months or less)  Unemployed (more than 6 months)  Unemployed (not in labor force)  Retired  Unknown/not reported  Youth ages 14-24 who are neither working nor in school  N/A | | | | Medicaid  Medicare  Private/Employment Based  Self-Insured/Direct Pay  None  State Children’s Health Insurance Program  State Health Insurance for Adults | | | | Affordable Care Act Subsidy  Childcare Voucher  Housing Choice Voucher  HUD-VASH  Other  Permanent Supportive Housing  Public Housing  SNAP  WIC  None | | | |
| **First Name** | | | | **M.I.** | | | | **Last Name** | | | |
|  | | | |  | | | |  | | | |
| **Social Security Number** | | | | **Date of Birth** | | | | **Gender** | | | |
|  | | | |  | | | | 🞎 Female 🞎 Other  🞎 Male | | | |
| **Ethnicity** | | | | **Race** | | | | **Education** | | | |
| Hispanic, Latino or Spanish Origins  Not Hispanic, Latino or Spanish Origins | | | | American Indian/Alaskan Native  Asian  Black/African American  Native Hawaiian/Other Pacific Islander  Other  Unknown/Not-reported  White | | | | Grade 0-8  Grades 9-12/Non-Graduate  High School Grad/GED  12+ Some Post-Secondary  Education  2 or 4 Year College Graduate  Graduate or other post-secondary school | | | |
| **Client Disabled?** | | | | **Military Status** | | | | **Is Client a US Citizen?** | | | |
| Yes No | | | | Veteran  Active Military  Non Veteran | | | | Yes No | | | |
| **Work Status** | | | | **Health Insurance Type** | | | | **Non-Cash Benefits** | | | |
| Employed full-time  Employed part-time  Migrant Seasonal Farm Worker  Unemployed (6 months or less)  Unemployed (more than 6 months)  Unemployed (not in labor force)  Retired  Unknown/not reported  Youth ages 14-24 who are neither working nor in school  N/A | | | | Medicaid  Medicare  Private/Employment Based  Self-Insured/Direct Pay  None  State Children’s Health Insurance Program  State Health Insurance for Adults | | | | Affordable Care Act Subsidy  Childcare Voucher  Housing Choice Voucher  HUD-VASH  Other  Permanent Supportive Housing  Public Housing  SNAP  WIC  None | | | |

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Countable Income Information** | | | | | |
| Customer Name: | | Total Amount Received | | Period Received  (30, 90 or 365 days) | |
|  | | $ | |  | |
|  | | $ | |  | |
|  | | $ | |  | |
|  | | $ | |  | |
|  | | $ | |  | |
|  | | $ | |  | |
|  | | $ | |  | |
| Income Category: | | | Frequency: | | Total Amount: |
| Fixed | SSI  SSDI  SSA  Pension  Window/Widower’s benefit  Adoption Assistance  Alimony  Black Lung pension | | Weekly  Bi-weekly  Monthly  Yearly | | $ |
| Earned | Wages  Self-employment  Active Military Pay  Ohio Electronic Child care | | Weekly  Bi-weekly  Monthly  Yearly | | $ |
| Supplemental | Unemployment  Utility Assistance  Workers’ Compensation  Ohio Works First (TANF, ADC) | | Weekly  Bi-weekly  Monthly  Yearly | | $ |
| Other | Cash withdraws from: IRA, Annuities, Other investments  Lump sum payout from: SSI, SSDI, Estate & Trust settlements, Divorce settlements, insurance payout, lotter winnings  Interest Income | | Weekly  Bi-weekly  Monthly  Yearly | | $ |
| None | | | | | $ |
| **Total:** | | | | | $ |
| **Deductions:** | | | | | |
| Deductible Income: | | | Frequency: | | Total Amount: |
| Health Insurance Premiums  Health Care Spending Accounts  Medicaid Spend Down (deductibles)  Medicare Part D (RX premium)  Child Support paid-out  Attorney fees for estate or trust settlements | | | Weekly  Bi-weekly  Monthly  Yearly | | $ |
| **Total Household Income (Countable Income – Deductions)** | | | | | $ |
| **Federal Poverty Level:** | | | | | \_\_\_\_\_\_\_% |

I certify that this statement is true and correct to the best of my knowledge, and I authorize the release of any or all information necessary for verification purposes.

Applicant Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_

Approved by: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_

|  |  |  |
| --- | --- | --- |
| **Excluded Income** | | |
| Excluded Income: | Frequency: | Total Amount: |
| Agency Orange Pension  Veterans affairs, service related disability  Handicapped income (i.e. work programs for the blind or disabled)  Title V wages (i.e. senior employment programs)  Volunteers in Service to America Stipend (VISTA)  Work allowances (work requirement to receive OWF assistance)  Income earned by dependent minors  Tax refunds/rebates  Education assistance (grants stipends for tuition/books)  Stipends for foster care  Military allowances for subsistence  Ohio waiver program (Medicaid benefit for caregiver)  Prevention retention and contingency (i.e. emergency services, rental asst.)  transportation allowances (WIOA)  Proceeds from reverse mortgage  FEMA, cash payments  Title III Disaster relief emergency assistance | Weekly  Bi-weekly  Monthly  Yearly | $ |

|  |  |
| --- | --- |
| **Expenses: \*\* Please see TAB TWO Program Enrollment for full breakdown\*\*\*** | |
| Expense Type: | Total Monthly Expense amount: |
| Food | $ \_\_\_\_\_\_\_ |
| Shelter | $ |
| Child Care | $ |
| Transportation | $ \_\_\_\_\_\_\_ |
| Utilities | $ |
| Total: | $ \_\_\_\_\_\_\_ |

**Community Services Block Grant Application Details**

**\*\* Please see Services tracking sheet in TAB ONE if active enrolled ( this is for totals at exit)\*\*\***

|  |  |  |  |
| --- | --- | --- | --- |
| **Goals** | | | |
| Goal (FNPI): | Member: | Enrollment Date: | Achieved Date: |
| **Improved mental health** |  |  |  |
| **Decrease self blame and Isolation** |  |  |  |
| **Connect to resources** |  |  |  |
| **Obtain safe affordable housing** |  |  |  |
| **More Knowledgeable of Community Resources** |  |  |  |
| **More ways to plan for safety** |  |  |  |

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **CSBG DOMAIN** | | | | | |
| Activity/Service (SRV): | Description: | Member: | Quantity: | Amount: | Date: |
| **Domestic Violence Service** |  |  |  |  | Please see services tracking sheet in TAB ONE for individual dates services performed or connected. |
| **Rental Assistance** |  |  |  |  |
| **Security Deposit** |  |  |  |  |
| **Eviction Counseling** |  |  |  |  |
| **Landlord Mediation** |  |  |  |  |
| **Permanent Housing Place** |  |  |  |  |
| **Rental Counseling** |  |  |  |  |
| **Medical** |  |  |  |  |
| **Crisis Intervention/ Response** |  |  |  |  |
| **Advocacy** |  |  |  |  |
| **Support Group** |  |  |  |  |
| **Language Services** |  |  |  |  |
| **Case Management** |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |

**Services and Participation Agreement**

Region 16 homeless services offers assistance for households (individuals or families) experiencing homelessness. Participants agree to participate in housing search, maintain monthly appointments, provide required documentation, and work to reach their goals in order to reach housing stability. The purpose of this agreement is to state the terms and conditions under which services will be provided to program participants. This agreement will also detail the responsibilities of program participants, and what may result in termination of assistance.

|  |
| --- |
| ***Consent for Services*:**  **I agree to participate in the Region 16 housing program and understand it is a program that consists of a combination of financial assistance and supportive services. I understand the ultimate goal of the program is for each participant to be able to maintain their own independent permanent housing in the future. I agree to actively participate in housing search, maintain monthly appointments, and will submit required program documentation. I understand that I may withdraw from the program at any time, and agree to meet with Case Manager to close my household’s case. I further understand, non-compliance with program requirements will result in termination from this program.**  **Participant (HoH) Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_** |

**Participation Terms**

I understand and agree to adhere to all the guidelines stated herein which have been fully discussed with me and agree to voluntarily sign this contract. I also agree to truthfully report any problems, changes, or concerns that occur during the length of involvement with the program. I further understand that my active participation in the program’s services allows the Case Manager to support my household’s ability to achieve housing stability.

***Participant (HoH) Responsibilities/Obligations (Participant (HoH) must initial each of the following):***

1. I understand this assistance is **Temporary: ETH/RRH *I******must develop an Individualized Service Plan (ISP)*** to transition off of assistance. I will attempt to obtain/maintain a permanent housing subsidy (i.e. Housing Voucher), or increase my household income to maintain housing once assistance ends. \_\_\_\_\_\_\_\_ (Initials)

2. I understand that the total length of services depends is determined on a case by case basis. Factors affecting the length of services include; needs of the household, housing stability, and available resources. In your particular case, you are accessing Emergency Transitional Housing Some programs, like RRH and ETH. The length of services is 240 days ( 8months): PH ETH\_\_\_\_\_\_\_\_ (Initials)

3. I understand the unit obtained through the program must be my **only residence**. I understand that my household may not receive other housing/utility subsidies for any housing unit under any duplicative Federal, State, or local subsidy program. I understand that I cannot sub-lease/let/transfer lease to another household. \_\_\_\_\_\_\_\_ (Initials)

4. I agree to participate in the program’s supportive services which includes housing search (locating, obtaining and maintaining permanent housing). I agree to allow staff to release information about myself/household to potential housing providers in an effort to assist my household in obtaining housing. My Case Manager will only release information for the purposes of assisting my household, with the exception of mandatory reporting. \_\_\_\_\_\_\_\_ (Initials)

5. I understand that I need to report changes of my household income (gain or loss) to the Case Manager **within 10 days**. I agree to keep my Case Manager informed & updated of my lease compliance, income status, goal progress, rental payment plans/abilities, and other areas as needed/required. \_\_\_\_\_\_\_\_ (Initials)

6. I understand I am required to meet with my Case Manager every 30 days and provide all required documentation. I understand that I must coordinate with my Case Manager to schedule my required monthly meetings, (with at least one meeting in my unit every 6 months), during agency business hours. I understand that I must notify staff if I have a conflict with a scheduled appointment. If I repeatedly miss and/or cancel appointments, I understand I will not be in compliance with program service requirements, which may result in termination of assistance. I understand that I will need to meet with staff to review my exit strategy. I have the right to appeal this exit if desired. \_\_\_\_\_\_\_\_ (Initials)

7. My HH’s housing financial assistance & projected subsequent assistance (if applicable) is as follows: \_\_\_\_\_\_ (Initials)

**NOT APPLICABLE TO EMERGENCY TRANSISTIONAL HOUSING WITH COMMUNITY ACTION COMMISSION OF FAYETTE COUNTY’S PEACE HOUSE DOMESTIC VIOLENCE PROGRAM**

8.. I will **follow all aspects of the lease** – I agree to follow Ohio Landlord-Tenant Laws and comply with the lease to the best of my ability. As such, I agree to the following:

* I will not commit any serious damage to the unit, or permit any household member/guest to damage the unit (damage is understood to be any damage other than ordinary wear and tear).
* I will not have repeated violations of the lease.
* I understand that I must keep my unit clean and sanitary.
* I will be respectful of my neighbor’s right to a peaceful environment.
* I will avoid illegal activities and comply with lease/property rules surrounding the pet policy, lawn/grounds maintenance, overnight guests, etc.
* I understand that my HH’s compliance allows staff to advocate on my behalf while also maintaining a positive relationship with my current landlord, as well as future landlords.
* I will report to the landlord, or building staff, any problems with plumbing, lights, appliances, air conditioning, heating, etc. \_\_\_\_\_\_\_\_ (Initials)

9. I understand that I/my household must not commit fraud, bribery, or illegal/violent acts including drug related activities in the unit or on the property. I understand that if my unit is vacant due to my incarceration for a time period greater than ETH: 0 days, I will no longer be eligible for assistance. If my recertification falls during my incarceration, I will be immediately exited from the program. \_\_\_\_\_\_\_\_ (Initials)

11. I understand that continued participation in the housing assistance program must be re-determined every

**PH ETH: 90 / max 240days** days. **My recertification date is** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_. I understand that if I do not provide required documentation, and recertify by this date, my participation in the program is automatically terminated. \_\_\_\_\_\_\_\_ (Initials)

***Termination of Assistance***

If the participant violates program requirements and/or this agreement, the program may recommend ending the rental/utility assistance for the participant. If the participant is nonresponsive, program staff must make three attempts to contact them. The three attempts should not be using the same method. The termination process may include, but is not limited to:

1. Written/verbal notice to the participant detailing reasons for termination:
   1. Not following program requirements or agreement
   2. Participant request to withdraw from ETH

If I do not agree with the reasons for my termination from the program, I may follow the grievance process as provided below:

***Grievance Process ( copy of policy and form given to client)***

There are three (3) steps to the grievance process:

1. Discuss the grievance with the staff member involved. An open discussion will usually clear up any misunderstanding and/or resolve any grievance. If the grievance remains unresolved, move on to step 2.
2. Request a grievance form and complete it. Forward grievance to the DV Director, Halona McCracken, 1400 US RT 22 NW, WCH, OH 43160

. If you are unable to fill out the grievance form in writing, you may request a personal meeting with the Homeless Director. S/He will review the grievance and respond in writing to the participant within five (5) working days of receipt of the report. If the participant remains dissatisfied with the resolution offered, s/he may take the next step. Or, in the case that the grievance is with the Homeless Director, move to step 3.

3. Request that the grievance form be forwarded to the Executive Director for review. S/He will take one of the following two (2) steps:

* + - Give the participant a written response which would indicate the final disposition; or
    - Call a conference for the parties involved in the incident(s). The final disposition will be issued within five (5) working days of the conference.

If the decision is not satisfactory, you may file a request for an administrative appeal. Submit your written appeal, along with the response of this agency, to Aaron Bryant @ aaron.bryant@ohioattorneygeneral.gov

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  
 **Participant (HoH) Signature**  **Date   
*(Provide copy to HoH)***

**Housing History Assessment**

**Participant (HOH) Name: Date:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

|  |
| --- |
| 1. Describe a time when you were successful in housing and/or were able to fulfill a lease: |
|  |
|  |
|  |
| 2. What resources, or circumstances, were present in your life that made your successful housing described in question #1 possible? |
|  |
|  |
| 3. What services, or programs, do you think will help you establish & maintain successful housing now? (i.e. RRH, CJH, PIPP, SNAP, Medicaid, etc.) |
|  |
|  |
| 4. What are your expectations and/or goals from participating in the program? |
|  |
|  |
|  |
|  |
| 5. Have you had any evictions? 🞏 Yes 🞏 No If yes, how many? \_\_\_\_\_\_\_\_\_\_\_ How long ago? \_\_\_\_\_\_\_\_\_\_\_ |
|  |
| *List Housing Challenges: (i.e. homelessness, past evictions, etc)* |
|  |
|  |
| *List Housing Strengths: (i.e. employment, ability to work, income, etc)* |
|  |
|  |

**Participant (HoH) Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_**

**Case Manager Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_**

|  |  |  |  |
| --- | --- | --- | --- |
|  | **Current Status for Participant** | **Case Manager Responsibilities** | **Participant Responsibilities** |
| **Income:** |  | Update file as needed |  |
| **Employment:** |  | Update file as needed |  |
| **Housing Situation:** |  | Provide Housing Resource | Participant is actively  seeking housing |
| **Food:** |  | Provide Community Resource | Utilize Food Pantries &  SNAP assistance if available |
| **Childcare:** |  | Refer to JFS Childcare if applicable |  |
| **Children’s Education:** |  | Refer to Head Start if applicable |  |
| **Adult Education:** |  | Provide if requested |  |
| **Legal:** |  | Refer to Southeastern  Legal Aid (if applicable) |  |
| **Health Care:** |  | Refer to JFS for Medicaid if applicable | Maintain JFS appts  or apply if needed |
| **Life Skills:** | Refer to Housing History Assessment | Update as needed |  |
| **Mental Health:** |  | Refer to Local Mental Health Agency if applicable |  |
| **Substance Abuse:** |  | Refer to Local Recovery Agency if applicable |  |
| **Support Network:** |  | Update file as needed |  |
| **Transportation:** |  | Refer to transportation services if applicable |  |

**Self Sufficiency Action Plan**

**Participant (HoH) Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Participant (HoH) Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_**

**Case Manager Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_**

**Budget Worksheet**

**PARTICIPANT (HoH) NAME: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DATE: \_\_\_\_\_\_\_\_\_\_\_**

|  |  |  |
| --- | --- | --- |
| **Monthly Expenses** | **Estimated Amt** | **Actual Amt** |
| Rent |  |  |
| **Utilities: Electric Plan to Enroll PIPP: Y N HEAP:  Y  N** |  |  |
| **Gas Plan to Enroll PIPP: Y N HEAP:  Y  N** |  |  |
| Water |  |  |
|  |  |  |
| Cell phone |  |  |
| Food expenses covered by SNAP benefit | **(**  **)** |  |
| Food expenses (include ***if*** HH need exceeds SNAP benefit)  ***\*Calculates @ $50/person weekly (ex: 2 person HH; 50x2=100wkly. 100 x4= 400 monthly)*** |  |  |
| Baby Formula and/or Diapers |  |  |
| Transportation: (car payment, gasoline or transportation fare) |  |  |
| Child Care |  |  |
| Medical ( prescriptions, co-pays, medicine needs) |  |  |
| Insurance ( Automobile, Renters) |  |  |
| Household Supplies |  |  |
| Personal Needs (clothing, haircut, shoes, etc) |  |  |
| Tobacco Use |  |  |
| School Expenses (fees, lunches, books, tuition, etc) |  |  |
| Installment loans or other Debt Payments (Payday Loans, Fines, Court Costs, etc.) |  |  |
| Storage Unit (\**NOT counted when housed*) |  |  |
| Child Support Payments |  |  |
| Savings (please specify) |  |  |
| Other (please specify) |  |  |
|  |  |  |
|  |  |  |
| **A: *TOTAL MONTHLY COSTS***  Exclude Food expenses covered by SNAP benefit |  |  |
| **B: *TOTAL NET MONTLY INCOME***  Include: Wages, child support, SSI, OWF (any eligible income): ***Do NOT include SNAP benefit.*** |  |  |
|  |  |  |
|  | | |
|  | | |

**Participant (HoH) Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_**

**Case Manager Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_**

|  |  |  |  |
| --- | --- | --- | --- |
| **Housing Search Case Plan**  **Participant (HoH) Name: Date:** | | | |
|  | | | |
| **Phase** | **Goal Date** | **Participant Responsibility** | **Case Manager Responsibility** |
| 1 | Housing Search Phase  Goal Date: \_\_\_\_\_ /\_\_\_\_\_ /\_\_\_\_\_  (14 days)  Date  Achieved: \_\_\_\_\_ /\_\_\_\_\_ /\_\_\_\_\_ | Use housing search tools to establish at least one solid housing lead by the end of this week. Solid lead includes:  1. Price Range within Budget/Rent Reasonable guidelines: $ \_\_\_ \_\_ - $ \_ \_ \_\_\_  2. Area you prefer to live in (County or Town/City): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  3. Appropriate # of bedrooms: \_\_\_\_\_\_\_\_\_  4. Immediate availability  5. Is selected & approved by you! | 1. Provide housing list and any potential housing leads for participant to follow up.  2. Provide program information to potential landlords on participant’s behalf, and assist in finding appropriate housing, if needed.  3. Connect to public transit, if available.  4. Assist in negotiating housing approval. |
| 2a | Housing Approval Phase  Goal Date: \_\_\_\_\_ /\_\_\_ \_\_ /\_\_\_\_\_  (14 days)  Date  Achieved: \_\_\_\_\_ /\_\_\_ \_\_ /\_\_\_\_\_ | 1. Contact Case Manager to schedule an inspection of potential unit. Verify that utilities WILL be on for inspection of unit. If needed, contact utility companies to turn on utilities at address, ***if*** landlord has agreed to inspection of unit.  ***Unit* *must* *be* *inspected* *before* *signing a lease!!***  2. Provide all required documents for financial assistance to Case Manager (copy of signed lease, signed Rental Assistance Agreement, completed Lease Review worksheet) | 1. Schedule and conduct habitability/ lead-based inspection of the unit.  2. Inform participant and landlord of inspection results. If inspection passes, help facilitate move-in. If inspection fails, work with landlord to complete needed repairs or, work with participant to locate new housing if repairs are excessive.  3. Discuss all required documents for financial request with landlord. (Signed rental assistance agreement, copy of signed lease, completed W9 etc). |
| 2b | **Barrier Resolution Phase** *(skip* *if* *housing* *is* *obtained within* *14 days)*  **New Goal Date:**  \_\_ \_ /\_\_\_\_\_ /\_\_ \_\_  Date Achieved:  \_\_\_\_ /\_\_\_\_\_\_/\_\_\_\_\_ | If housing approval is not established within 14 days, it may be necessary to schedule 1 or 2 solutions-focused meetings with Case Manager to resolve barriers related to your housing search. List scheduled the meeting dates & time below:  1. date/time\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ @\_\_\_\_\_\_\_\_\_\_\_  2. date/time\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_@\_\_\_\_\_\_\_\_\_\_\_ | 1. Schedule solution focused meetings to review housing search plan with participant.  2. Discuss barriers to participant obtaining housing approval and support them in finding resolutions to those barriers.  3. Contact several landlords on participant’s behalf and attempt to get preliminary approval from at least one landlord. |
| 3 | Housing Move-In Phase  Goal Date: \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  (21 days)  Date  Achieved: \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_ | 1. When unit passes inspection, meet with landlord to sign lease. Provide copy of the SIGNED lease to Case Manager. Work with landlord to obtain keys and make arrangements to move in to housing.  2. Call utility companies once address, and move-in date is known and make arrangements to turn on services for move-in date. Contact Case Manager for assistance if needed. | 1. Obtain all completed documents required for Purchase Order/Check Request. (W9, copy of Signed Lease, My Lease worksheet from participant) 2. Schedule first home visit appointment with participant.  3. Help participant transfer utilities through assistance/referrals if needed. |
| ***A******copy******of this form******MUST******be******given******to******the******participant.******The******original******will be kept in the******participant******file.***  **Participant Signature: Date:**  **Case Manager Signature: Date:** | | | |

**Services Tracking Form**

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| --- | --- | --- | --- | --- |
| Participant (HoH) Name: Date: | | | | |
|  |  |  |  |  |
|  | Service | Provided/Referred To  (Circle One) | Agency or Service  (Provided/Referred To) | |
|  | Furniture Assistance | Provided Referred |  | |
|  | Utility Assistance | Provided Referred |  | |
|  | Food Pantry | Provided Referred |  | |
|  | School clothing Voucher | Provided Referred |  | |
|  | Job Training/ Placement Referral | Provided Referred |  | |
|  | Schooling/ Training/ Education asst | Provided Referred |  | |
|  | Mental Health Counseling | Provided Referred |  | |
|  | PRC Assistance | Provided Referred |  | |
|  | Second Chance | Provided Referred |  | |
|  | Metropolitan Housing | Provided Referred |  | |
|  | Landlord Advocacy | Provided Referred |  | |
|  | Budget Counseling | Provided Referred |  | |
|  | Eviction Prevention Information | Provided Referred |  | |
|  | Lease Review | Provided Referred |  | |
|  | Head Start/Help Me Grow | Provided Referred |  | |
|  | Jobs & Family Services | Provided Referred |  | |
|  | Salvation Army | Provided Referred |  | |
|  | Social Security | Provided Referred |  | |
|  | Substance Abuse Counseling | Provided Referred |  | |
|  | Child Care Assistance (Title 20) | Provided Referred |  | |
|  | After-School/ Summer Camp Program | Provided Referred |  | |
|  | Other | Provided Referred |  | |
|  | Other | Provided Referred |  | |

**Participant (HoH) Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Case Manager Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Confidentiality Agreement**

***Confidentiality is protecting another person’s right to privacy***Information participants reveal to their Case Manager will not be discussed with anyone else. This means that the Case Manager will not reveal a participant’s personal information to anyone, without participant’s written permission, unless required by law. Furthermore, it is agreed that participants will not discuss their HH’s participation, the specific amount of financial assistance received through the program, or time enrolled in with persons not affiliated with the program, or its partners.

***A Release of Information***

This form is used to obtain this permission between the Case Manager and participant. This Confidentiality Agreement form serves as the permission between the Case Manager and participant to allow Case Managers to meet, get acquainted, and discuss social and personal interests provided with other community and social service providers and program evaluators.

***Exceptions to the Right of Confidentiality***Case Managers are asked to report information to the Coordinator and/or Supervisor that is required by Federal or State law. This includes information that indicates a participant is endangered, exploited, or is related to suspected fraudulent activity or other violations of the law.

***Confidentiality Pledge***As your Case Manager, I agree to protect your right to privacy and confidentiality. I will not disclose any information about you unless I am required to do so by law, or authorized to do so through your signed release.

**Participant (HoH) Signature Date**

**Case Manager Signature Date**

**STAFF CERTIFICATION OF ELIGIBILITY - ETH ASSISTANCE**

**Purpose:** This form serves as documentation that: (1) the program participant named below meets all eligibility criteria for Region 16 housing assistance; (2) this eligibility determination is based on true and complete information; (3) neither the staff member making this determination nor her/his supervisor are related to the program participant through family, business or other personal ties; and (4) this eligibility determination has not resulted from, nor will result in, any financial benefit to the staff member making this determination, his/her supervisor, or anyone related to them.

**Instructions:** This form must be completed for each program participant upon the determination of her/his - eligibility for Region 16 housing assistance. This form must be signed and dated by homeless housing staff person and homeless housing supervisor who determine a household’s eligibility. This form must be kept in the program participant’s case file. This form will remain valid, unless a different homeless housing staff person re‐determines the household’s eligibility, in which, case a new form will be required.

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| --- |
| **Participant (HoH) Name:** |
| **Enrollment Date**: |
| **\*List all members of household**: |
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*\*All members in household that will benefit from housing assistance must be listed here.*

**Required certifications:** Each person signing below certifies to the following: (1) To the best of my knowledge, the program participant named above meets all requirements to receive assistance under Region 16 housing assistance. (2) To the best of my knowledge and ability, all of the information used in making this eligibility determination is true and complete. (3) I am not related to the program participant through family, business or other personal ties. (4) To the best of my knowledge, neither I, nor anyone related to me, has received or will receive any financial benefit for this eligibility determination. (5) I understand that fraud is investigated by the Department of Housing and Urban Development, Office of Inspector General, and may be punished under Federal laws to include, but not limited to, 18 U.S.C. 1001 and 18 U.S.C. 641. (6) I understand that if any of these certifications is found to be false, I will be subject to criminal, civil and administrative penalties and sanctions.

**Case Manager Signature: Date:**

**Supervisor Signature: Date:**